Smallpox Initial Workgroup
July 24, 2002 Final Minutes
3:00 – 5:00 PM
State Laboratory Institute/RM 133

Attendees: Claire Maranda, Anita Arnum, Ralph Timperi, Leonard Marcus, Kathy Brinsfield, Bill Bicknell, Mary Sheryl Horine, Barbara Kelleher, Tara McCarthy, Judy Zaido, Connie Liese, Richard Seder, Patty Cicchetti, Barbara Werner, Pat Kludt, Howard Saxner, Gloria Rudisch, Nancy Ridley, Barbara Westley, Susan Lett, David Ladd, Bela Matyas

Facilitator: Alfred DeMaria, Jr, MD
Director, Bureau of Communicable Disease Control
Assistant Commissioner

Support: Robert S. Goldstein, MPH
Director, Division of Epidemiology & Immunization

Dr. DeMaria convened the meeting and welcomed the participants. Participants were asked to introduce themselves and state their affiliation.

Dr. DeMaria noted that the workgroup was not a closed process and discussed the practical aspects of achieving the goals and objectives of BT Preparedness and Response Program Advisory Committee. He added that input is always welcome and encouraged communication both by attending meetings and via e-mail.

The mission of the CDC BT Preparedness and Response Program Advisory Committee was reviewed and the role of the initial Smallpox Workgroup was described. The Advisory Committee and Smallpox workgroup are composed of representatives from various state and local agencies, organizations and other disciplines. The advisory committee advises DPH on BT preparedness and response. The critical capacities and benchmarks relevant to smallpox preparedness and response of the CDC and HRSA cooperative agreement were reviewed.

The initial Smallpox Workgroup was convened with the specific purpose of developing a recommendation to DPH that responds to the Advisory Committee on Immunization Practices' (ACIP) recommendations issued on June 20, 2002. The ACIP recommendations include:

1. targeted pre-event vaccination;
2. pre-designation of facilities to deal with smallpox cases; and
3. development of smallpox response teams.

CDC is currently considering the ACIP recommendations and, as of yet, has not made a final determination. The presumption is that CDC will agree with the ACIP

recommendations. It is unclear how much vaccine will be made available for this purpose. DPH is requesting a recommendation from the workgroup that addresses how to respond to, receive and care for a person with smallpox. Discussion followed regarding who should receive vaccine in a pre-event situation and who would be placed at risk of exposure to a smallpox case. The anticipated resources were discussed which included balancing the unmeasurable risk of smallpox against the required resources, and the direct, indirect and opportunity costs associated with pre-event preparedness.

Several assumptions related to smallpox response planning (distributed by Dr. DeMaria) were reviewed and included the following:

- Vaccinia-naïve populations would be expected to have a 30-50% mortality from smallpox infection.
- No smallpox is currently circulating; no quantitative risk assessment can be made of the risk of smallpox.
- Risks of vaccinia in an unvaccinated population are not known; furthermore, vaccinia presents an unquantitated risk to unvaccinated contacts of vaccinated individuals. Vaccinated individuals can excrete vaccinia virus for 2-3 weeks.
- Currently available vaccine is under IND status. It will take 2-3 years to complete the testing of the vaccine. Only historical supplies of the vaccine are currently available. With a 1:5 dilution, 75 million doses are available in 500 doses/vial to be administered using a bifurcated needle. Written consent, HIV testing and other testing will be required. History of eczema or eczema in the family will exclude the individual from vaccination.
- Vaccination within four days of exposure is protective against severest illness and may prevent disease.
- Diluted vaccine (i.e. 1:5 dilution) has a higher rate of local adverse events and satellite lesions.
- Vaccine not included in the National Vaccine Injury Compensation Program and issues of indemnification are unresolved.

Discussion followed regarding the need for pre-designated facilities to receive an identified case of smallpox. Issues of preventing transmission and the provision of medical care to the case were discussed at length and included the need for Type C, X, R facilities. Participants noted that initial smallpox case(s) could occur anywhere in Massachusetts, any first-responder may therefore be exposed, and any hospital may be required to serve as the receiving facility. The extent of the contamination at the receiving facility was discussed. The role of hospitals in facilitating smallpox transmission is well documented.

It is anticipated that the first case of smallpox will expose multiple individuals. The resources to receive and care for a smallpox case(s) that would need to be assembled was discussed. The required response in the first three hours, next three hours, etc. was reviewed in the context of the goal of preventing secondary and tertiary cases. Workgroup participants discussed the idea of sharing (i.e. staff and other resources) with other hospitals to leverage economies of scale in post-exposure events. Certain number

of staff within each pre-designated facility to care for patients was felt to be a key component of the smallpox response plan. It was noted that resources are not static and that staff that receive the vaccination would need to be tracked and new staff would need to be vaccinated. Vaccinated individuals would be held to their ethical commitment to participate during a smallpox event. CDC would pre-determine the amount of available vaccine and provide guidelines on how it should be distributed. The smallpox response plan needs to be retrofitted depending upon the amount of vaccine received. Seventy-six (76) hospitals within Massachusetts have emergency departments (ED). The need to establish infection control parameters, and isolation and quarantine rooms with the appropriate negative pressure and/or HEPA filters was reviewed.

The workgroup reached consensus that every hospital was felt to need to have the capacity to deal with the first case of smallpox. Hospitals are already required to perform TB assessments and have committed resources to providing appropriate airborne isolation. The management of staff vaccination needs to be conducted in a stepwise fashion to minimize the potential impact of the hospital's operations. It was felt that all categories of staff serving the smallpox case would need to be considered for vaccination.

Significant issues exist with respect to vaccinating hospital staff. Specific issues such exclusion or furlough from work of staff receiving the vaccination and addressing adverse events of vaccination remain unresolved. Other important issues include security of the vaccine supply, and assurance of the ongoing availability of a vaccinated staff.

Next Meeting: Friday, August 9th at 10:00AM in RM. 133 at the State Laboratory Institute in Jamaica Plain, MA.

Primary Topic for Discussion*:* Composition and number of smallpox response teams.

Deliverable: Draft DPH smallpox response recommendation for pre-designated facilities.